Hometown Direct Primary Care

332 N. Bright Leaf Blvd, Suite C
P.O. Box 2559
Smithfield, NC 27577
Phone (919) 901-7344   Fax (319) 250-7453

Medical Records Release Form

Patient Name: ____ DOB: ________________________

Address: ____

Parent/Guardian/Responsible party* (if applicable): ____

*This person must match information provided on the Patient Information Form.

Please give name and address of medical facility you are authorizing your medical records to be released from:

Physician/Clinic: ____

Address:____ City/State/Zip: ________________________

Phone: ____ Fax: ______________________________________

I authorize my medical records be released to:

Physician/Clinic/Person: ____

Address:____ City/State/Zip: ________________________

Phone: ____ Fax: ______________________________________

Check all records to be released:

□ All medical records   □ Lab/Test Results   □ Billing Information

□ Mental Health records   □ HIV/AIDS tests/results   □ Drug/alcohol use/abuse

□ Other ____

Limitations of records to be released: □ None or □ Other ____

Specific dates of records requested (last 10 years unless otherwise noted): __________________________________

Purpose of records being released:

□ Continuity of care   □ Personal copy   □ Insurance claim

□ Legal claim   □ Disability claim   □ Other ________________

I understand that:

- I may refuse to sign this authorization and that my refusal has no impact on receiving treatment.
- I can inspect any information disclosed under this agreement.
- My signing this document is voluntary.
- I can revoke this authorization at any time in writing, except to extent this authorization has already been acted upon.
- I can receive a copy of this authorization.
- This authorization expires 6 months from the date it is signed unless otherwise noted.

Signature: ____ Date: ______________________